



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Narcotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for quantity requests greater than 30 patches/month for Duragesic and/or 90 tablets/month for OxyContin. PA is also required for dosages that exceed 200 mcg/hour for Duragesic and/or 240 mg/day for OxyContin.

Effective May 1, 2004, hydromorphone powder, levorphanol powder, and oxycodone powder will require PA. Effective June 1, 2004, Duragesic and OxyContin will require PA. Additional information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

Section I Narcotic request    Strength    Quantity (Complete a separate line for each strength prescribed.)			Dose, frequency, and duration of requested drug	Drug NDC (if known) or service code
<input type="checkbox"/> Duragesic (fentanyl)    _____    _____			<b>Indication</b> (Check one or all that apply.) <input type="checkbox"/> Cancer pain (specify type and stage): _____ <input type="checkbox"/> AIDS: _____ <input type="checkbox"/> Other (specify): _____ Please specify: <input type="checkbox"/> Active treatment <input type="checkbox"/> Palliative care	
<input type="checkbox"/> Duragesic (fentanyl)    _____    _____				
<input type="checkbox"/> OxyContin (oxycodone)    _____    _____				
<input type="checkbox"/> OxyContin (oxycodone)    _____    _____				
<input type="checkbox"/> Other: _____				
Please complete for all narcotic PA requests.			Has member tried sustained-release morphine or methadone? <input type="checkbox"/> Yes. Complete box below. <input type="checkbox"/> No. Explain why not. _____	
			<div><div>Drug name</div><div>Dates of use    Dose and frequency</div><div>Did member experience any of the following? <input type="checkbox"/> Adverse reaction    <input type="checkbox"/> Inadequate response    <input type="checkbox"/> Other Details of adverse reaction, inadequate response, or other: _____ _____</div></div>	
			How is the member's response to treatment being measured (e.g., pain-assessment scales, activity level)? _____ _____	

## Medication information (cont.)

### Section II

Please complete if the request is for Duragesic at doses > 200 mcg/hour, for OxyContin at doses > 240 mg/day, or for compounds.

Is the member under the care of a pain specialist? ☐ Yes ☐ No

Name of specialist: \_\_\_\_\_ Phone no.: ( ) \_\_\_\_\_

Date of last visit or consult with pain specialist: \_\_\_\_\_

What is the complete pain-management regimen, including other pain medications, adjunctive therapy, and/or controlled substances? Please include the names and doses of these medications. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the member had a psychological evaluation? ☐ Yes ☐ No

Does the member:

have a history of substance abuse or dependence? ☐ Yes ☐ No

have a history of alcohol abuse or dependence? ☐ Yes ☐ No

Does the member have a treatment agreement (e.g., lock-in pharmacy and prescriber, early refill policy, consequences of nonadherence to treatment)?

☐ Yes (Attach copies.) ☐ No (Explain why not.)

\_\_\_\_\_  
\_\_\_\_\_

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )
Address		City	State Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State Zip
E-mail address			Telephone no. ( )	Fax no. ( )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date